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Testimony of Sheldon Toubman before the Human Services Committee in Opposition to Governor's Proposed Cuts in SB 843, and in Opposition to HB 6524, Which Would Move Elderly and Disabled Medicaid Recipients into HMOs

I am a staff attorney with New Haven Legal Assistance Association, specializing in access to health care under publicly-funded programs. Thank you for the opportunity to testify before you in opposition to the Governor's draconian cuts to health care contained in Bill 843 and also in opposition to Bill 6524, which would set in motion a plan to move elderly and disabled fee-for-service Medicaid recipients into capitated HMOs which make money by restricting access to care.

Opposition to Bill 843

Because the Governor does not propose to completely eliminate the Medicaid, SAGA or ConnPACE programs or to tighten the financial eligibility tests for Medicaid and HUSKY, some may view her cuts in Bill 843 as moderate. In fact, either alone or taken together, they are severe and would **decimate access to care under our essential Medicaid, HUSKY, ConnPACE and SAGA programs**, causing dramatic increases in expensive and inappropriate (and sometimes too late) treatment in hospital emergency departments. Here are just some of those cuts:

- **Elimination of all adult coverage for dental care** under Medicaid (including HUSKY), except for "emergencies," while subjecting most dental care for children to prior authorization (Sections 44 and 45)
- Elimination of all Medicaid-like health coverage for non-citizens **legally** present in the country for fewer than five years, except for "emergencies" (Section 8)
- **Gutting of the definition of medical necessity under Medicaid** (including HUSKY), so it will be much harder to argue that the state or, more likely, a HUSKY HMO, has to pay for specific medical services prescribed by a patient's doctor (e.g., treatment which is merely maintaining someone's health but not bringing improvement), and so the state or the HMO will be able to substitute much cheaper services or items that do not work nearly as well (Section 60)
- Elimination of **medical interpretation services** for patients who don't speak English (Section 40)
- Imposition of **unaffordable premiums on HUSKY A adults** with incomes over 100% of the federal poverty level, which will be **as high as 20% of the cost of**

the service (potentially equaling $40 per month for these low income HUSKY enrollees)

- Imposition of **unaffordable copays on adults** (including HUSKY parents) with incomes over 100% of the federal poverty level, which will be **as high as 5% of the family's income,** in addition to the high required contributions to premiums (Section 19)
- **Extensive cuts to pharmacy benefits under all programs**

All of these cuts are severe but I will focus on the pharmacy cuts which the Governor has proposed across the board. The pharmacy cuts fall into three general categories: new program eligibility restrictions, high cost-sharing, and drug access restrictions (drugs not available at all or subject to burdensome prior authorization). These cuts will completely predictably result in our most vulnerable populations going without specific drugs or without any drug coverage whatsoever.

New Eligibility Hurdles for ConnPACE:

Bill 843 (Section 17) would implement an asset test and eliminate the COLA for income eligibility for ConnPACE, so far fewer people would qualify for this program—and this is despite the fact that the last time the legislature implemented an asset test for this program, it was repealed almost immediately upon going into effect because of the large number of elderly and disabled who dropped off as a direct result.

Even if one qualifies for ConnPACE, the bill would impose a sharply limited open enrollment period of only six weeks at the end of each year. While there would be exceptions for individuals who newly turn 65 or newly become eligible for Social Security Disability Insurance or SSI, there would be no exception, for example, for the individual over 65 who was healthy and needed no medications and so was not enrolled in ConnPACE, but who develops a serious neurological condition suddenly and becomes in need of several medications for chronic conditions. They may have to wait as many as ten months for any coverage under ConnPACE.

New and Higher Premiums for HUSKY A and ConnPACE:

Besides the new high premiums for adults on HUSKY A, Bill 843 (also Section 17) would also increase the annual premiums under ConnPACE from $30 to $45. Both of these increases will predictably result in many individuals ceasing to participate in the program at all because of the competition with other needed expenditures, like rent, utilities and food. Individuals at the low end of the income scale just don't have disposable income that they can use to cover such fees.

New Copays for Drugs and Other Services Under Medicaid:

The Connecticut legislature has **twice** implemented copays for drugs for Medicaid and SAGA recipients and **twice repealed** them (the first time, in six weeks; the second time, in a few months) because of the direct interference with access to needed medications which resulted. This result applied even to the $.50 copays applied one of these times, since most individuals are on more than one medication. Nevertheless, in Section 19 of Bill 843, the Governor would again impose copays not only for drugs but for other services.

The Governor suggests these copayments will not be burdensome because the copays for drugs will be capped at $20 per month and all copays will be capped at 5% of income. But for an individual with an income of $910 per month (exceeding 100% of the federal poverty level) and the need for both several medications and doctor visits each month, that translates to **copays of $45 per month**—an unaffordable expense. And if the person has slightly more income and also is paying a $40 premium for their coverage under HUSKY A, the expected total contribution could be **$100 or more each month**, which is not going to be possible for anyone on Medicaid to maintain.

The result, once again, is that individuals will go without medications rather than part with money they need for other necessities.

Gutting the Part D Wraparound for Dual Eligibles:

As is well known by seniors across the country, the Medicare Part D plans have severely restrictive formularies and exceptions for non-formulary drugs are very hard to obtain from them, especially for confused seniors and disabled individuals with debilitating illnesses. Since all Medicaid coverage for drugs for dual eligible (Medicare/Medicaid) recipients was eliminated in January 2006, Connecticut took the responsible action of covering these non-formulary drugs at least initially and then contacting the Part D plan on the individual's behalf to petition it to pay for these drugs, if possible; in the meantime, access to drugs equal to what was available to them under Medicaid **before** the onset of Part D was assured. This essential "wraparound" protection for non-formulary drugs also was adopted for individuals on both Medicare Part D and ConnPACE.

The other responsible action Connecticut took at the time was to cover the new copays for dual eligible Medicare/Medicaid enrollees under their Part D plans. Though relatively modest (initially $1 to $5, now up to $6), copays of this size are, for the reasons set forth above, unaffordable for individuals also on Medicaid, and thus the legislature has twice repealed them. It didn't want to make the same mistake again and so, in 2006, it adopted a "wraparound" for the Part D copays immediately upon implementation of Part D.

In both cases, the goal of the wraparound accomplished by the legislature was to "hold harmless" this exceedingly vulnerable population in terms of their access to needed medications.

Nevertheless, Sections 15 and 66 of Bill 843 would eliminate these essential components of the wraparound for Part D. This would be devastating to dual eligible recipients who will simply go without many of the drugs their doctors having been prescribing. The explanation in the Governor's budget summary-- that, "under federal rules,... in those cases where a particular non-formulary drug is medically necessary, plans are required to provide coverage" through an exception process, and therefore "it is anticipated that clients will continue to receive needed medications through Medicare Part D"-- is preposterous. The inability of this exception process to meet the need for non-formulary drugs under Part D has become a major national concern and, indeed, the legislature's completely accurate prediction that this would be the case was the basis for its adoption of the wraparound in the first place.

Including Psychiatric Drugs Under DSS's Restrictive Preferred Drug List and Subjecting Other Drugs to Burdensome Prior Authorization:

Under DSS's restrictive Preferred Drug List (PDL), now applied to all enrollees in ConnPACE, SAGA, Medicaid and even HUSKY (since pharmacy was carved out from the HUSKY HMOs in February of 2008), drugs not on the list are available only through a prior authorization (PA) process, which is designed to discourage the use of these drugs and in fact does so in part because of the burdensomeness of the PA process. However, more problematic is the fact that doctors routinely write prescriptions for prior authorization-only drugs without first requesting such authorization, owing to the complexities of different and frequently changing long drug lists, with the result that their patients show up at the drug store with a prescription for a drug lacking PA which is then rejected for payment on the pharmacist's computer. Absent an automatic temporary supply being electronically authorized at the pharmacy counter, the patient, lacking credit cards or other independent resources, will simply walk out of the pharmacy with **none** of the drug their doctor ordered.

As troubling as this is generally, this is a major concern particularly for individuals in need of psychiatric medications, some of whom may be disinclined to take these medications anyway due to unpleasant side effects, and who therefore are unlikely to follow up with their psychiatrists to advise of the lack of access. Absent followup, their conditions will simply go untreated.

For these reasons, Connecticut, like many states, has exempted all psychiatric medications from prior authorization under the preferred drug list. Section 46 of Bill 843 would remove this exemption entirely. Including mental health-related drugs on the preferred drug list such that some of them will be subject to PA means that these drugs will become difficult to obtain, and some patients, denied access to these drugs, will decompensate and need to be hospitalized at great expense to the state, which now administers **both** pharmacy and behavioral health benefits directly (not through capitated HMOs), even for HUSKY enrollees.

The same is true for the Governor's proposal in Section 18 of Bill 843 to impose PA on certain high cost drugs **regardless** of whether the drugs are on the PDL. Imposing PA on these drugs will make them harder to obtain, and threaten patients who need these drugs. In addition, several years ago, **DSS on its own successfully asked to have a similar requirement** which had been passed by the legislature (prior authorization for all drugs costing more than $500) **repealed**- because it turned out to be more expensive to administer this process than the money it purportedly saved. Imposing PA on drugs simply because they are expensive is not rationally related to the level of need for these drugs and has already been tried and rejected by the legislature as cost-ineffective. There is no need to re-try this failed policy.

The additional proposed requirement of Section 18, requiring prior authorization for certain off-label uses of drugs for children, including the off-label use of anti-psychotic drugs, regardless of whether the drug is on the PDL beginning July 1, 2010, will severely restrict access to additional psychiatric drugs, this time specifically for children. The pharmacists' computers are not programmed to allow input of specific diagnoses or medical conditions. As a result, there is no way that the state's system will be able to tell for what purpose the drug was prescribed, including whether it was prescribed for an off-label use. This means that the only way that DSS can as a practical matter impose PA on psychiatric drugs for children on the PDL which might be prescribed for an "off-label" use is to deny access to **all** psychiatric drugs prescribed for children which **might** be prescribed for such a purpose, unless PA was already obtained. Of course, it is unlikely that a prescriber would know in advance that such PA was necessary, let alone actually request it in advance. The harmful rejections at the pharmacy will as a result go far beyond those drugs not on the PDL.

Eliminating Automatic 30-Day Fill for Prescriptions Requiring Prior Authorization for Which Prior Authorization Was Not Obtained

Particularly coupled with the increased imposition of PA on prescription drugs generally, the elimination of the critical protection of an automatic 30-day temporary supply of PA-only drugs for which PA has not been obtained, as provided in Section 18 of Bill 843, will have a devastating impact on access to prescription drugs for the 345,000 low income HUSKY enrollees, most of whom are children.

DSS discovered, through the experience with its Medicaid Managed Care Organization (MCO) contractors, which managed pharmacy benefits under HUSKY until February 1, 2008, that busy doctors routinely write prescriptions for drugs which require PA without first requesting PA, and thus their patients end up being denied access to these drugs at the pharmacy counter. In the case one of these HMOs, Health Net, data developed in a lawsuit against that company showed that **approximately 3,000 times every month** a HUSKY enrollee, just in this one plan (not the largest), walked out of the pharmacy with neither the drug they were prescribed nor a temporary supply of it. Since most HUSKY enrollees are under age 18, this meant that it usually was a child who went without the medication their doctor had prescribed, as a direct result of the MCOs' PA requirements.

Thus, on its own, another MCO, CHNCT, instituted a system of essentially automatic electronic authorization of one-time temporary fills of such PA-only drugs at the pharmacy counter, coupled with follow up to the prescribers of these drugs. When it took over the pharmacy benefits for all HUSKY enrollees in February 2008, DSS announced it would be following the system adopted by CHNCT to protect all of the HUSKY enrollees in the new pharmacy carve-out. It adopted some, but not all, of these essential

CHNCT protections, but, critically, it ensured that, for the first fill of a new drug subject to PA, patients lacking the resources to pay out of pocket would not walk out of the drug store without a PA-only drug their doctor prescribed, by electronically notifying the pharmacist immediately that a temporary 30-day supply was available, even in the absence of a pending request for PA.

This was done because DSS recognized that its limited 5-day supply for "emergencies" was, and continues to be for the elderly/disabled population, very difficult to obtain, and is **unavailable in the situation where a drug subject to PA has not yet had a request for PA submitted.** Rather, the 5-day temporary supply for "emergencies" is available only after the prescriber has **already** requested PA and is simply waiting for a decision; absent a PA request being pending at the time of the presentation of the prescription at the pharmacy, or the pharmacist taking time away from patients in line to call a doctor and get him or her to request PA immediately, even the 5-day supply is unavailable.

Eliminating the essential protection of an **automatic** temporary supply, which CHNCT adopted, and which DSS itself also adopted because of the obvious harm without it, would ensure that vulnerable HUSKY enrollees, mostly kids, would routinely go with many of their needed prescriptions unfilled, just as they did under the deeply troubled MCO pharmacy system. Indeed, bad practices such as denials at the pharmacy, which the DSS takeover of the HUSKY pharmacy benefits from the MCOs was designed to end, will become codified under the Governor's bill.

I note that the automatic temporary supply requirement adopted for the HUSKY population in February 2008 was **not** adopted for the elderly/disabled population (they only have the very hard to access "emergency" 5-day supply). Advocates have tried without success to get DSS to adopt what was made available to the HUSKY population for the elderly/disabled population. But now, rather than address this problem, the Governor's proposal is to go backward: drop the HUSKY population, including kids, down to this same lowest common denominator of severely restricted access to any drugs subject to PA.

<u>Elimination of coverage for most over the counter drugs under Medicaid</u>

While most of the cuts above involve eligibility restrictions, higher cost sharing and access restrictions through prior authorization, in some cases, drug coverage will be eliminated entirely. This is the case with most over-the-counter drugs for adults under Medicaid. Under Section 18 of Bill 843, only insulin and insulin syringes will remain as an over-the-counter covered service. While many Medicaid enrollees will thus be denied access to medications, others will speak with their doctors, who will then write prescriptions for **prescription** versions of the same drugs, which will then be paid for, but at a much higher cost, under Medicaid.

In sum, I urge you to reject all of these cuts to essential health care programs contained in Bill 843 as needlessly harmful to our most vulnerable populations. Particularly since Connecticut will be receiving $1.32 billion from the federal government in stimulus payments specifically through enhanced **Medicaid** reimbursement, if the state is going to take this extra Medicaid money and use it for other purposes to fill the budget gap, at a minimum, it should at least not take **away** benefits from the recipients under Medicaid and the other state health insurance programs. Indeed, last week, speaking to the nations' governors, President Obama said "our administration will begin distributing more than $15 billion in federal assistance under the Recovery Act to help you cover the costs of your Medicaid programs," to ***"help ensure that you don't need to make cuts to essential services Americans rely on now more than ever."*** (See February 23, 2009 White House Press Release, http://www.whitehouse.gov/the press office/President-Obama-Announces-15-Billion-in-Medicaid-Relief-from-ARRA-Headed-To-States/)

Opposition to Bill 6524

Based on the ongoing experience with the HUSKY HMOs for the generally healthy family and child population already enrolled in them, capitated HMOs covering the Medicaid population tend to have severely inadequate provider networks. But this reality will go unmentioned by the HMO marketers urging vulnerable elderly and disabled Medicaid recipients to sign up with their plans. And, because of the obvious financial incentives, even if the HMO the enrollee chooses includes his or her current doctor, the HMO will often deny access to care when that participating provider requests it. Given the access problems these HMOs already create for low-income HUSKY families, this clearly can't be a good thing for the even more vulnerable elderly/disabled Medicaid recipients, with multiple medical conditions and very low incomes.

There is a myth that proponents of HMOs commonly invoke in support of moving the elderly and disabled population to HMOs: that this population needs to have its care coordinated and the HMOs coordinate care which would not otherwise occur. But this rarely occurs now—even under the HUSKY contracts which already require it. Similarly, in the case of Oregon, which has experimented with HMOs for its elderly and disabled population, the reality has been quite the opposite. As one Oregon advocate, Attorney Timothy Baxter of the Lane County Legal Aid and Advocacy Center, recently explained:

> In our collective experience serving many hundreds of elderly and disabled [Medicaid] participants over the years, true case management ... ha[s] been, not just ineffective, but generally nonexistent.
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> The officers of commercial health plans have, quite literally, a legal *duty* to their corporate shareholders or other owners to maximize profits to the fullest permissible extent. The conflict of interest in assuming the role of public servant invades the innermost core of the health plan's mission. To have any hope of keeping the health plan from unchecked fulfillment of its own corporate nature, the most rigorously faithful oversight must be maintained without letup.

> My own county served as a truly catastrophic illustration of how badly things can go wrong. In 2000 and later years, the state's oversight of Lane County's MCO failed -- totally. As a result, the Lane County MCO ran wild over the rights of its disabled and elderly [Medicaid] members. Improper, unexplained denials of requests for medical equipment and supplies became the norm. Delay, stonewalling, and other hardball private insurance tactics, became standard operating procedure.

In sum, the movement of elderly and disabled Medicaid enrollees to the HMOs will severely restrict their access to needed health care. Nevertheless, it is possible that the proponents of this bill believe it will at least save money. But this is a myth too. It is not at all clear that having moved the HUSKY population into HMOs will save money relative to the well-functioning non-risk system most of them were in before February 1, 2009. Moreover, based on the years of experience with the Bush Administration encouraging Medicare Advantage HMOs to enroll essentially the same population, placing the elderly and disabled Medicaid population in capitated HMOs will be **more** expensive than continuing to administer health care directly to this population under the DSS-run Medicaid fee-for-service program.

Although the Bush Administration had managed to bring HMOs into the Medicare program and keep them there, this has only been possible at a frightful price to the taxpayers: HMOs have been willing to stay in that program because of the profits made possible through heavy subsidization of these plans by the federal government, such that they **on average cost the taxpayers 14% more than it would cost to provide the same care under the traditional government-run Medicare program.** President Obama has specifically identified this excessive cost as an example of waste in the health care system which must be eliminated.

For all these reasons, I also urge you to vote "no" on Bill 6524.

Thank you for the opportunity to speak with you today.